

Kryssarvägen 10, Näsby Park, Sweden
21 Nov., 1960

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Dear Owen,

I have thought over the questionnaire you sent me, dated Nov. 2, with some care. Some of the answers come to me as something of a surprise, and I thought it might be better to answer in this letter form for reasons of conciseness and because my handwriting has not improved since I was with you. I have numbered paragraphs as your inquiries were numbered.

I Decision to study medicine.

1. I was about 20 and in my junior year at Harvard when the decision was first firmly made to become a physician.

2. This decision had been debated with my family and alone since the death of my father when I was 14, in 1923. It was not an easy one to make, as I wished to go into engineering, which held great fascination for me. The decision was more difficult when one of the faculty in physics at Harvard urged me to stay there after graduation. I suppose the decision was finally made when my mother pointed out that my father had hoped I would go into surgery, but had felt it not wise to say so openly. I also felt guilty because my scholarship led my mother to spend half the family income on my education, and that I should therefore pay great attention to such preferences as she quoted my father as having had.

3. Included in (2) above.

II Decision to become a surgeon.

1. The decision to become a surgeon was a foregone one in the light of item 2 above.

2. This decision was much more easily reached than whether to go into medicine in the first place.

3. The factors which influenced this decision were:

a) Parental influence.

b) The possibility of more decisive action than in other fields of medicine

c) Later, during my Fellowship with you, I spent six months, and then another year, in physiology. The decision to come back to surgery at this time was not an easy one to make. It was made because it appeared to me possible to contribute more in both areas as a surgeon than as a physiologist.

III Suggestions for improvement of the educational process in the training of surgeons.

a) Eliminate the archaic items from the medical school curriculum, eg., many details of anatomy, latin prescription writing, excessive amounts of psychiatry, etc. Such a move could permit the student to finish medical school earlier than at present.

b) Blend present collegiate and medical school curricula so medical school subjects begin two or three years after high school and so that some of the humanities continue far through medical school. A joint

course of perhaps 6 years might possibly be constructed without loss and with perhaps gain in addition to the saving of some of the most productive years of the man's life.

- c) Provide a strong fourth-year clerkship so that the better student may eliminate the internship altogether.
- d) Take away the arbitrary time requirements of the specialty boards and let each man progress as a conscientious teacher thinks he can.
- e) Provide a research environment and research opportunity throughout school and graduate training.
- f) Provide a broad clinical experience. Today most large hospitals are riddled with crippling specialty board plans which make it impossible for the same man to learn to do good abdominal surgery, good gyn. surgery, good urologic surgery, and perhaps a good tonsillectomy without being on old-age subsistence before he is through. He does not need to know all about all these areas, but he should have the opportunity to learn what the problems are, first-hand.

IV The essentials of an ideal arrangement for the surgical academician in a university atmosphere.

- a) Removal of the limitations of interests and activities imposed by the specialty boards. (Perhaps many of the specialty boards should be eliminated too)
- b) Some means of correction of the present practice of selection of Chairmen of departments on the basis of research and surgical and teaching ability, only to put them to work in administration, in which so many are not competent at all. A professional administrator under the Chairman of the Department should help. It should also help to permit every man in the department to pursue research personally.
- c) Private patients must be allowed to faculty members in order to keep them alive professionally. I have seen it happen at our school that faculty members have begun to die on the vine from lack of personal responsibility for patients. This was the reason for entering into voluntary hospital activities in the neighborhood, which move has tremendously helped. For this reason, the new University Hospital here is planned to be 2/3 private.
- d) Earnings from private patients pose a problem everywhere. They should be but a supplement to a sizeable straight salary, otherwise these private earnings tend to pull a man away from the productive academic work for which he is presumably best equipped. Such an arrangement facilitates also the taking of sabbatical leaves.
- e) The excessive earnings which an academic surgeon may accidentally gain should not be a pawn in the hands of the administration of the medical school. The surgeon should not be expected to support the school, for such a move makes him a financial prop instead of a possible academic pioneer.
- f) The enterprising academic surgeon should be entitled to channel his own excess earnings into his research undertakings. Probably the Chairman of the Department should be entitled to guide the use of such funds wisely.
- g) The total economic return of academic full-time surgeons should be adequate to permit them to participate in local and national professional societies and activities without embarrassment. It is reasonable that it should be substantially more than that of the basic science people, for more selection is used in the first place, more years of training are needed in the second, and more continuously gruelling responsibility, as for individual patient safety, wears upon them in the third.

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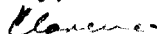
h) The training program should be in the heart of a great university if possibility, as the rewards for faculty and students are tremendous. This is the biggest single problem in Brooklyn. William Carlson tried to change it and failed.

i) Cordial, reliable, and imaginative relations must exist between the department of surgery and the administration, and between the department of surgery and other departments in the school. In this regard we are very fortunate in Brooklyn.

j) The above considerations are means to an end. The atmosphere in the department must be cordial to students and faculty alike, must foster an inquisitive attitude in all, and must be intellectually and morally sound.

Now you can see why I did not use the form you sent! My very best to you and Sally.

Sincerely,



Clarence Dennis

P.S. I said nothing about income ceilings because I don't know what to say. We are permitted 50% of the salary in private earnings which is good if the salaries are proper. Ours are not yet proper, but seem to be improving. The problem exists especially for assistant and associate professors here.

